Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JOHN A SAZY MD
431 OMEGA DRIVE STE 104
ARLINGTON TX 76014

Respondent Name
American Home Assurance Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-0231-01

MFDR Date Received
September 24, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient had a posterior fusion of L5-S1. This constitutes two segments."

Amount in Dispute: $790.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 22614 correctly denied for payment, as additional level was not fused."

Response Submitted by: Hoffman Kelley, 5316 Hwy, 290 West, Suite 360, Austin, TX 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 13, 2011	Outpatient Services	$790.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.203 sets out medical bill submission requirements for health care providers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B12 – SERVICES NOT DOCUMENTED IN PATIENTS' MEDICAL RECORDS.
   - 275 – THE CHARGE WAS DISALLWED; AS THE SUBMITTED REPORT DOES NOT SUBSTANTIATE THE SERVICE BEING BILLED.
   - 5036 – Complex Bill – Reviewed by Medical Cost Analysis Texas

Issues

1. Did the insurance carrier support its reasons for denying the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance company denied the disputed services as B12 – "SERVICES NOT DOCUMENTED IN PATIENTS' MEDICAL RECORDS." Per 28 Texas Administrative Code §133.210(b)(c)states in pertinent part; (b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents. (c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:(1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes; (2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500: a copy of the operative report…" Review of the submitted documentation found no operative report. The insurance company denial is supported.

2. The requestor did not support the services were separately payable. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 11, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.